CMA Looks Ahead

Approaching the Time for Decision

The President and the Chairman of the Council Address Medicine's Problems

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The Hard Choices Facing American Medicine

JEAN F. CRUM, M.D.,
President, California Medical Association

THE ACHIEVEMENTS OF MEDICINE in this country have been great. Few would argue the point. But today we cannot afford the luxury of recounting past accomplishments. Rather, we must devote our energies to assessing the future—and preparing for it.

In his novel *1984*, George Orwell painted a bleak picture of the future for western man—a society in which government keeps itself in power by complete control over man's actions and his thoughts. The following is from Orwell's book:

> "The Ministry of Truth . . . was startlingly different from any other object in sight. It was an enormous pyramidal structure of glittering white concrete, soaring up, terrace after terrace, three hundred meters into the air. From where Winston stood it was just possible to read, picked out on its white face in elegant lettering, the three slogans of the Party:
>
> FREEDOM IS SLAVERY
> IGNORANCE IS STRENGTH . . ."
> WAR IS PEACE

"Ignorance is strength." That sounds like some of the bureaucratic jargon we hear today.

The year 1984 is still 12 years away. But some of Orwell's predictions seem to be taking shape already. Government is playing an ever-increasing role in our everyday lives. Some segments of our society are "hooked" on drugs. Our system of free enterprise is steadily being eroded. Individual initiative has almost become old fashioned.

In many ways, we in the medical profession have been among the first to be hit by this "wave of the future." It is not necessary to recount the steady encroachments of the Federal Government on the practice of medicine. Nor is it necessary to emphasize the almost unbelievable strides taken by medical science in the recent past. We have just emerged from a decade in

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CMA Priorities and Communications

JOHN T. SAIDY, M.D.,
Chairman of the Council

ON FOUR PREVIOUS OCCASIONS, 1967, 1968, 1969 and 1970, the Council has presented the House of Delegates with proposed Goals and Objectives for the California Medical Association.

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which more and greater change has taken place than any other decade in the world's history. And even more important for us today, the decade that we have entered promises to make the past appear placid by comparison.

Society will change, regardless of our actions. Our duty—our responsibility—is to bring our energy to bear on this change, to assure that it serves the best interests of our patients and our nation. But what happens if our efforts are of no avail? What happens if government decides simply to absorb the medical profession? Have we carefully considered all of our alternatives in such an event? Clearly, we have not.

Not long ago I had an opportunity to discuss the plight of our profession in the province of Quebec with a surgeon who had witnessed the whole series of events there. He told of the frightful toll that loss of personal freedom took upon the physicians in that province. He noted that good physicians—conscientious, reputable, outstanding physicians—left Quebec during that tempestuous period. Clearly, they had not anticipated the future in time. We must learn from such experiences. We must chart the various possibilities for our future and devise well-reasoned, workable alternatives.

What would we do if we found ourselves faced with an untenable situation in which to practice medicine? Would we speak ineffectually with fragmented voices and be forced to comply, giving in meekly to government edict? Or, could we justify the effective withholding of our services—as some doctors in other countries have done? Somewhere between these two extremes must lie workable alternatives. To learn of them and to utilize them effectively, we must become thoroughly familiar with what has happened in other countries—in England, Belgium, the Scandinavian countries, in Quebec.

Does the answer lie in the adoption of the guild structure by medicine? Perhaps the whole nature of medical societies must change. We must intelligently weigh the various courses of action open to us. Should medical organizations in the future concern themselves primarily with politics, or with socio-economics, or solely with the exchange of scientific knowledge?

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While the goals adopted in 1970 will be reevaluated by the Council in light of attitudes expressed by the 1972 House of Delegates, we believe that in general the Association maintains its commitment to these previously stated goals.

Our particular concerns at this time are primarily those of priorities and communication.

Priorities

We believe that CMA's various programs must be subjected to intensive scrutiny from the standpoints of priority, current relevance, progress toward achievement and appropriate involvement at the proper membership level. Continual program analysis and performance review are mandatory to help us work more effectively on fewer and more significant tasks. If needs and problems determine organizational structure and not the reverse, we have a real chance to streamline the Association focusing its activities on the most important and appropriate objectives. We can then minimize unrewarding peripheral involvement in so many areas which disperse our efforts, effectiveness and funds, and are often rather unproductive in the end.

Although there may be general agreement on goals, a rational delineation of spheres of activity and the roles of the various levels of membership and leadership in CMA programs is necessary. The essential attributes of such programs are anticipation, consideration, decision and action. With proper assignment, overlapping can be minimized and more participation achieved with a better balance of effort. The template of the CMA structure may not be appropriate for county medical societies and vice versa since the degree and manner of such participation in so many activities will vary considerably.

Peer Review serves as an example of such proposed coordination. Utilizing the existing and potential activities of physicians at each level of organized medicine in California, the California Peer Review Organization was created by the California Medical Association to anticipate the increasingly important need for physician direction of all forms of Peer Review within the state.

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Should medical societies continue their attempt to combine all three? Would it be appropriate for a subsidiary organization to function wholly for the purpose of collective bargaining—having flexibility and toughness in promoting the enlightened self-interest of physicians? Solutions are not simple or easily derived. I do urge that we thoroughly consider these questions. Now.

In 1964, a long-time critic of organized medicine said: "The AMA—operating from a platform of negative vigilance—presents no solutions but busily fights each change and then loudly supports it against the next proposal." Perhaps this is the way that we are viewed by some of the American public. By how great a segment—who knows? Certainly in some minds organized medicine represents the forces of reaction in health care rather than the forces of constructive leadership.

What will happen if people of this belief—regardless of its merits—are in a majority and their opinions prevail? Do we become conformists? Or do we face a future of increasing discord and confrontation? It is essential that we find the means to establish those principles upon which we can stand. We must examine—and then reexamine—those beliefs we currently hold that may be challenged. We must know where we stand and we must be able to support our positions with strength and conviction. To prepare for a confrontation, we must be able to speak from competence. There are activities in which our participation now will undergird us for the challenges that lie ahead.

By competent self-regulation the profession may remain, in the words of Vannevar Bush, "so respected that public opinion itself will insist on its independence [in order to] maintain and enhance the characteristic which should be essential in every profession: devoted service to the people, exercised with pride and dignity."

Peer review, its continued implementation, expansion and refinement, offers us this opportunity. Peer review—that means appropriate evaluation of physicians' activities by other physicians without contractual relationship with government or other third parties. Peer review

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Selected for their demonstrated expertise, the physicians composing the new CMA Commission on Peer Review are developing an organization which is oriented towards the encouragement of a continuation and refinement of existing Peer Review mechanisms using a variety of local approaches to assure quality care for the public. Although all of organized medicine is involved in this critical task, implementation of a California Peer Review Organization involves specific division of functions at the local and state levels.

Physicians at the local level, through their county medical societies and with the assistance of their executive staffs, are responsible for maintaining a systematic program of review of all health care and costs in their respective areas focusing upon quality of care, utilization and charges.

California Medical Association, through its Commission on Peer Review, is responsible for the statewide administration and coordination of the California Peer Review Organization; for the development and coordination of the educational aspects of peer review; for appellate review; for research and development of regional norms; for performance evaluation of peer review mechanisms, not peer review itself; and, for assisting and encouraging local review units as requested, or as indicated.

Different levels of participation, different forms of responsibility, but a commonality of purpose make the California Peer Review Organization a unique and exciting opportunity for all, physicians and staff alike, who share medicine's commitment to better patient care.

Communications

The cliche of communications being a two-way street remains true. However, if there is any reason for intraprofessional communication it is to keep the profession alive. The same can be said for communications to the general public and to all who have assumed the burden of provision of medical care as theirs. Reiteration of goals and programs is necessary although to those now on the Council it may not seem so after the first few times. To the non-member and

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—that includes an evaluation of the propriety and effectiveness of care rendered, as well as its quality.

Our recently formed Peer Review Commission of the California Medical Association has an almost awesome responsibility. Like Caesar's wife, it must be above suspicion. It must merit the total acceptance and wholehearted cooperation of all our physician members. It must be pure, free of all financial entanglements with governmental agencies that would effect constraints against its acceptability and effectiveness. Our peer review program may incorporate these desirable qualities and also include public accountability as well.

CMA's program of Continuing Medical Education also affords the public tangible evidence of quality care. Voluntary participation by a much larger percentage of our membership is urgently indicated if this program is to serve as an effective deterrent to compulsory recertification and relicensing.

Our desire to improve upon our present system of medical care—to correct its deficiencies and build upon its strengths—is exemplified by our continuing concern for improving access, maintaining and elevating quality and controlling costs.

To add to these efforts, to counter our detractors and strengthen our position, we need to be more effective advocates for the merits inherent in the private system of medical care. In the words of Doctor Dwight Wilbur, "The voluntary association of two men, one giving and one seeking relief—this is the heart of the art of medicine." Without question, the "art" suffers irretrievably from the loss of the "heart."

Recent discriminatory price controls on physicians are onerous. While physicians properly seek fair treatment, we are a part of the body politic and must participate in the solution of national problems. We must, by self-regulation, exercise constraint on our fees or accept the risk of pricing ourselves out of freedom.

All of these programs and preparations, to be effective, must be based on a strong and unified CMA, broadly representative of all physicians in California. Unity in this context is

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uninvolved member it also seems unnecessary but for different reasons. Those physicians who choose non-membership or non-involvement must be informed of CMA activities and their positive benefits and results for both their patients and themselves.

Council membership is in itself an intense educational experience, the results of which need to be told to the membership. The exposure to differing points of view within the profession is a salutary one resulting in increased understanding and respect for one's confreres and their ideas. In most instances, there follows a general informed consensus on courses of action which are in the best interest of the public and the profession. More important, perhaps, though less rewarding and often more traumatic in the personal sense, is the exposure to the non-medical community, which is so actively manifesting its interests in all aspects of health care. This leads to a feeling among many physicians, particularly those who are not directly involved, that there is a near national conspiracy to take the direction of health care away from the professionals. This is only partly true.

On the political front there are empty promises, grandiose plans and a harmful and disturbing evocation of false expectations. The last carries with it the implied criticism of the professionals that failure to deliver on such political promises is further proof of the need for governmental or non-professional control, the devastating consequences of which are never mentioned.

On the other hand, those who are most sanguine about the complexities of the system are strongly in favor of a pluralistic approach and the least possible governmental provision or control of services. Well aware of the cost involved and the real expectations of any system, they are particularly desirous of increased medical participation at the earliest possible moment in the design of all aspects of proposed changes. They, too, deplore the simplism of the politicians and share medicine's conviction that professional matters are not soluble by rhetoric or political means.

Medicine has this great chance, as it has always had, but because of the current political

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identified as unity of purpose. Different points of view and varied approaches to problems will persist in any healthy democratic organization—and indeed they should. But differences must not be disruptive. Unity of purpose must prevail. It will result in positive achievement and progress.

You may ask, What can one person do to promote unity? I say to you that you can set an example by emphasizing the positive, look for the goals and the objectives that we have in common, and cease to dwell upon matters in which we are different. Wisdom of two centuries ago states, "If men would consider not so much wherein they differ, as wherein they agree, there would be less of uncharitableness and angry feeling in the world."

I invite each and every physician to espouse this credo and to put it to work. You are organized medicine. Its continued effectiveness, or lack thereof, depends upon your efforts.

There exists within our organization, as in many others, a dissident group. They are critical of organized medicine. They participate in its affairs dispiritedly, if at all, and base their highly vocal disagreements primarily on socioeconomic grounds. They generate a remarkable volume of dissent. And they create ill-concealed satisfaction in those people who would take a meat cleaver to our present private system of medical care if they had their way.

In summary, then, we must continue in our attempts to provide effective solutions to the health care problems facing our nation. It is necessary that we—and all Americans—rethink some of our ideas about improving health care. The American public has not been made sufficiently aware that there are many other factors even more influential in a nation's health than medical care. Specifically, environmental protection and enhancement, inadequate general health education, automobile accidents and drug abuse are all factors to which our nation has devoted too little attention. Instead of making concerted efforts to attack these problems, Americans too often have fallen victim to the idea that new programs of government financing will perfect our system of health care.

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climate it may not have such future opportunities. Therefore, only a near-total response to the challenge will help us to preserve those elements which we know to be essential for the improved health care of the nation. This invitation is that medicine expand its social responsibility as a profession and take the lead in improving those elements of the system – quality, accessibility, availability—which will lead in Rutstein's words "to the ultimate goal of decreased disease, decreased disability, and decreased untimely death." Withdrawal or non-involvement will leave the field open for the incapable, the misinformed and the political. In Medicine's absence they will prevail; in its presence, they will fail and the entire nation will be better, not for their failure alone, but for our success. □

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Clearly, our health care problems—or any of our social problems for that matter—will not be eliminated by adding billions of dollars to public-sector spending. Unfortunately, too many of our citizens seem to equate spending money with making progress. What we need is not more dollars but better ways to use them. We need programs which are goal-oriented and which concentrate on achieving very specific, carefully defined objectives—such as offering solutions to problems like environmental pollution or inadequate housing, sanitation and nutrition. This approach might well prove to be the only really workable way to eliminate some of the deficiencies in American health care. On the other hand, there are the currently proposed legislative attempts at drastically restructuring our system of medical care. Using these, we might easily continue to pour endless billions of dollars into an indiscriminate quest for better health care—only to discover later that this goal has eluded us.

I do not have solutions to the problems that I have posed. My objective in raising them is

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to indicate that the various alternatives we face must be carefully evaluated and courses of action must be developed for each contingency.

I would like to quote from a lecture delivered by a contemporary scholar. It has relevance today for us as physicians—and for us as Americans.

"There are many ways in which a nation can die. It can die from internal strife, tearing itself apart. It can die of indifference, of an unwillingness to face its problems, an incapacity to respond to the suffering of its people. Or a nation can die of old age, not chronological so much as psychological old age—a waning of energy and an incapacity to learn new ways.

"There is no danger that we will fail to respond to the sweep of change. It forces our hand. The danger is that we will respond sluggishly. The danger is the creeping disaster that overtakes a society which little by little loses a commanding grip on its problems and its future."*

There is a Chinese imprecation that goes, "I curse you. May you live in an important age." We are living in an important age. We have hard choices ahead. Let history record that we were ready.

*John W. Gardner, The Godkin Lectures, Harvard University, 1969.

DIALYSIS UNITS—HIGH RISK AREA FOR VIRAL HEPATITIS

There are certain kinds of "critical care units" in which viral hepatitis and association with the Australia antigen have been unusually common. Dialysis units throughout the world are an example of this. In our own dialysis unit at the General Hospital here in Los Angeles, we have monitored 62 patients undergoing chronic dialysis. Forty percent have developed clinical viral hepatitis. An additional 22 percent have apparently been infected by the agent, showed no evidence of hepatitis, but began to circulate the Australia antigen.

. . .

Most impressive and what I want to emphasize is the spill-over into the personnel who have a contact with these patients. Nearly half of the nurses have developed frank hepatitis. A third of the technicians working in that unit have developed hepatitis. A tenth of the physicians, including house officers—residents who spend only a period of six weeks to two months in the unit—have developed frank icteric hepatitis. Most impressive of all is the fact that eight of the spouses of patients undergoing dialysis have developed acute viral hepatitis. They have all been the spouses of persistently antigen-positive dialysis patients.

—ALLAN G. REDEKER, M.D., Los Angeles

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